N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

N.C. STATE MATERNITY HOME FUND

RESIDENTIAL CARE PROVIDER REIMBURSEMENT REQUEST

TO: DHHS Controller's Office
Program/Benefit Payments Section
616 Oberlin Road
Raleigh, NC 27605
ATTN: Ellen Price

FROM: _____
Provider's Name

_____

_____
Provider's Address

_ _
_____
Provider's Social Security Number

RE: _____
Client's Name

Date Admitted: ____/____/____

Date Discharged: ____/____/____

Reimbursement request for month of_____, _____

_____ X $_____ = $ _____ Total Cost
Number of Days **Daily Rate**
- _____ Client Contribution
$ _____ State Maternity Home Fund Requested

_____ _____
Signature of Provider **Date**

_____ _____
Signature of Social Worker **Date**

DSS-6190 (Rev.01-99)
Adult & Family Services Section